STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to update the code status (a medical term that indicates a patient's wishes regarding resuscitation and life-saving measures in the event of a medical emergency) for Resident 193.This deficient practice had the potential to result in the resident receiving treatments they may not want which could prolong their suffering or interventions inconsistent with their values and/or preferences.Findings: During a review of Resident 193's Face sheet, [undated], the Face sheet, indicated, that Resident 193 was admitted to the facility 7/9/25 and there was no Advance Directives (AD-a written statement of a person's wishes regarding medical treatment) or code status noted for this Resident. During a review of Resident 193's Progress Notes, dated 7/18/25, the Progress Notes, indicated, that at 8:50 p.m. Resident 193 was found unresponsive, no pulse, no respiration.Registered Nurse (RN) declare the time of death at 8:50 p.m. During a review of Resident 193's Physician Orders for Life-Sustaining Treatment (POLST- document to ensure that a patient's wishes are respected by healthcare providers in emergency situations or when they are unable to communicate for themselves completed by a physician, nurse practitioner, or physician assistant, in consultation with the patient or their healthcare proxy), [undated], the POLST indicated that the POLST form was prepared and signed by Resident 193 on 7/13/25 stating Do Not Resuscitate-(DNR); Comfort Focused (maximizing comfort). The POLST form also indicated that the form was signed by the medical provider 7/25/25. During a concurrent interview and record review on 7/25/25 at 4:06 p.m. with Director of Nursing (DON), Resident 193's Orders, Progress Notes, Face sheet and POLST were reviewed. The Orders did not show documentation of code status. The Face sheet did not show documentation of code status. The Progress Notes did not show documentation of code status prior to the Resident expiring on 7/18/25. The POLST indicated, that the POLST form was prepared and signed by Resident 193 on 7/13/25. The POLST form also indicated that the form was signed by the medical provider 7/25/25. The DON stated that the code status should be near the Resident name on the electronic health record (EHR) screen. DON also stated that if does not see no order for code status in the orders, resident records and has been trying to get a copy from Ace Hospice but has not been able to and that the POLST was signed today (7/25/25) by the medical provider. DON stated that would be easier if code status was in the orders. DON stated that if don't see order then assume full code status (all possible life-sustaining measures to be taken in the event of cardiac or respiratory arrest). During a review of the facility's policy and procedure (P&P) titled, Physician's Orders for Life Sustaining Treatment (POLST), [undated], the P&P indicated, .Completion of the POLST form must reflect a process of careful decision-making by the resident. in consultation with the Physician, about the resident's medical condition and known treatment preferences. During a review of policy and procedures (P&P) at website, https://emsa.ca.gov/dnr_and_polst_forms/ , titled, DNR and POLST Forms, dated 2025, the P&P indicated, .The Emergency Medical Services Authority (EMSA) approved POLST form must be signed and dated by a physician, or a nurse practitioner or a physician assistant acting under the supervision of the physician, and the patient or legally recognized health care decisionmaker. The POLST form should be clearly posted or maintained near the patient.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to repair a moderate dent in the wall in Resident 107's room.This deficient practice had the potential to result in the resident not feeling or having a safe and/or homelike environment.Findings: During a review of Resident 107's Face Sheet, dated 7/24/25, the Resident Face Sheet indicated, Resident 107 was admitted to facility 4/9/24. During an observation on 7/24/25 at 12:32 p.m. in Resident 107 room, there was a large dented and exposed wall area behind the head of Resident 107's bed. During an interview on 7/24/25 at 12:36 p.m. with Resident 107, Resident 107 stated that the dented and exposed wall looks awful and that they would not have their home look like this. During a concurrent observation and interview on 7/24/25 at 5:07 p.m. with Environmental Director (ED) in Resident 107 room, ED stated that the indented and exposed wall should not be there and will take care of it. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, [undated], the P&P indicated, .The resident has a right to a dignified existence.Residents have freedom of choice, to maximum extent possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up on a grievance for one of 36 sampled residents (Resident 38).This resulted in Resident 38's grievance to go unresolved. During a review of Resident 38's Facesheet (information containing contact details, brief medical history at a glance), the Face Sheet indicated, Resident 38 was admitted to the facility on [DATE]. Review of the resident's Minimum Data Set (MDS, an assessment tool used to guide care) dated 5/1/25, indicated Resident 38 had a brief interview for mental status or BIMS score of 15 (BIMS score of 13-15 indicates intact cognition).During an interview with Resident 38 on 7/21/25 at 12:03. p.m., Resident 38 stated my 500 dollars was stolen a few months ago and nothing has been done about it. Resident 38 also stated he had reported the missing money to the Director of Nursing (DON) and had not heard anything back.During a concurrent interview and record review, on 7/23/25, at 3:25 p.m., with DON, DON stated Resident 38 informed her of the missing money after the incident happened. DON stated that a grievance was done regarding the incident but a review of Resident 38's records did not indicate any documentation of the resident's missing money. During an interview with the Administrator (Adm) on 7/23/25 at 4:30 p.m., Adm stated that if Resident 38 filed a grievance regarding his lost money, the facility needed to investigate and there should be documentation of the incident in the resident's records. Adm stated there was no grievance filed for Resident 38‘s lost 500 dollars. Adm also stated, she had not heard of the incident until 7/23/25 when it was brought to her attention. During a review of the facility's undated policy and procedure (P&P) titled, Misappropriation of Resident Property, the P&P indicated, Reports of misappropriation of resident property shall be promptly and thoroughly investigated. Reports of misappropriation or mistreatment of resident property are to be investigated through the resident grievance process. and documented in the progress notes or through the grievance process .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for one of three sampled residents (Resident 200) who smoked, the facility failed to ensure a baseline care plan was developed to address Resident 200's smoking.This failure had the potential to result in the lack of interventions to promote safe smoking.During a review of Resident 200's RFS, the RFS indicated Resident 200 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (infection in the bone), severe sepsis (serious condition resulting from the body's response to infection, can lead to tissue damage and death if not treated promptly), and generalized anxiety disorder (mental health condition, persistent and excessive worry about various aspects of life). During an observation and interview on 7/22/25 at 4:42 p.m. with Resident 200, there was an open pack of cigarettes on the overbed table. Resident 200 stated going out to smoke four times a day and that the facility staff had allowed cigarettes to be kept at the bedside. During a concurrent interview and record review on 7/24/25 at 4:06 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 200 smoked independently. LVN 5 stated the lighters and cigarettes were stored at the nurse station but was not sure if Resident 200 had some cigarettes at the bedside. LVN 5 stated a safe smoking assessment was initiated on 7/6/25 that indicated Resident 200 was a smoker but was not completed. LVN 5 also stated there was no baseline care plan completed to address Resident 200's smoking. LVN 5 stated the importance of ensuring smoking materials like cigarettes are not kept at the bedside, as residents could end up smoking in the room and potentially cause a fire. During a review of the Baseline Care Plan Summary (BCPS) dated 7/7/25, the BCPS did not indicate that Resident 200's smoking was addressed. During an interview on 7/25/25 at 3:55 p.m. with Minimum Data Set Coordinator (MDSC), MDSC stated any assessments upon admission would be completed by the admitting nurse, and any baseline care plan that should address the assessment results would be completed by the same admitting nurse. During a review of the facility's policy and procedure (P&P) titled Smoking Policy, undated, indicated a Safe Smoking Assessment is going to be completed to ensure safety or residents who may smoke and other residents other than smokers. The P&P also indicated, all residents that desire to exercise the privilege to smoke will be assessed to determine their smoking safety awareness, Interdisciplinary team (IDT, a group composed of individuals from different departments) will determine if a resident is a safe smoker, the Safe Smoking Assessment will be completed at the next morning meeting, following the resident's admission to the facility. Regardless of the Safe Smoking Assessment result, residents will need to keep smoking materials in the nurse station. Care plans will be developed based on assessment and findings of the IDT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on observation, interview and record review, for two sampled residents (Resident 15 and 184), the facility failed to provide podiatry referrals to treat their long toe nails. This failure did not provide necessary services for treatment and foot care to these residents. During a review of Resident 15's Face Sheet dated 7/24/25, the Face Sheet indicated Resident 15 was admitted to the facility in November 2023.During a review of the Resident 15's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 4/25/25, it indicated Section B indicated Resident 15 had clear speech, able to express ideas and wants, and has the ability to understand others. Section C indicated Resident 15's a BIMS (Brief Interview for Mental Status-a standardized cognitive assessment tool) score: 14, intact cognition.During a review of the nursing Progress Note, dated 3/21/25, for Resident 15, the nursing note indicated resident wants to see the podiatrist, referral given to social service office. During an interview on 7/24/25 at 1:25 p.m., Resident 15 stated her toe nails are gross, terrible, that the nails are curling over her skin and toenails really need to be clipped. Resident 15 stated the last time she was seen by podiatry was 1 1/2 years ago. During an interview on 7/24/25 at 12:06 p.m., with Social Services Director (SSD), the SSD is responsible to coordinate resident referrals to podiatry. SSD stated the last time Resident 182 was seen by podiatry was in December by referral. During a review of the undated P&P, titled Podiatry Services, the P&P indicated scheduling and coordination of podiatry visits will be scheduled regularly (e.g., every 61 days routinely or as clinically indicated, or on an as-needed basis for acute issues all podiatry appointments will be documented in the facility's scheduling system and communicated to relevant staff and residents by the Social Services Director/designee. 2. During a review of Resident 182's Face Sheet dated 7/24/25, the Face Sheet indicated Resident 182 was admitted to the facility in May 2023.During a review of Resident 182's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 5/14/25, Section B indicated Resident 182 had clear speech, able to express ideas and words and has the ability to understand others. Section C indicated Resident 11's BIMS (Brief Interview for Mental Status score: 11, moderate cognitive impairment.During an observation on 7/21/25 at 12:19 p.m., Resident 182 was laying on top of his covers in bed. Resident 182's feet were bare and toenails long, curved and jagged. During an observation on 7/21/25 at 1:47 p.m., Resident 182 was observed in the hallway sitting in his wheelchair propelling with his bare feet. During a review of Resident 182's face sheet, Resident 182 had diagnoses to include congestive heart failure, psychoactive substance abuse and hypertension. During a concurrent interview and record review on 7/24/25 at 12:06 p.m., with Social Services Director (SSD), the SSD stated it was her responsibility to coordinate resident referrals to podiatry. SSD stated the last time Resident 182 was seen by podiatry was in December by referral. The SSD provided a physician order, dated 7/26/24 indicated to refer Resident 182 to house podiatry for history of nail fungus infection (onychomycosis). During a review of the undated P&P, titled Podiatry Services, the P&P indicated scheduling and coordination of podiatry visits will be scheduled regularly (e.g., every 61 days routinely or as clinically indicated, or on an as-needed basis for acute issues all podiatry appointments will be documented in the facility's scheduling system and communicated to relevant staff and residents by the Social Services Director/designee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for two sampled residents (Resident 199 and 200), the facility failed to ensure an environment free of accident hazards and failed to ensure residents receive adequate supervision when:1. Resident 199 left the facility unsupervised. This failure had the potential to result in significant risks to resident's safety.2. Resident 200 had cigarettes at the bedside. This failure had the potential to result in fire hazards. 1.During a review of Resident 199's Resident Face Sheet (RFS), the RFS indicated Resident 119 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), other non-toxic encephalopathy (brain disease), congestive heart failure and pleural effusion (fluid buildup around the lungs).During an interview on 7/21/25 at 10 a.m. with Resident 199, Resident 199 stated there was no reason to stay in the facility, and that staying longer would make Resident 199 lose the apartment. Resident 199 had expressed wanting to go home.During an observation between 7/21/25 and 7/22/25, Resident 199 was seen walking along the hallway, sometimes sitting on the couch around the corner near the Administrator's office, looking sad and worried. During an interview on 7/24/25 at 2 p.m. with Director of Nursing (DON), DON stated Resident 199 went out on pass on 7/23/25 and did not return to the facility.During a joint interview on 7/24/25 at 4:06 p.m., with the Medical Records Director (MRD) and Receptionist (REC), MRD stated that if a resident went Out on Pass (OOP, refers to someone who has been granted temporary leave from a place such as a facility), they should sign out in the OOP binder at the nurse station. MRD stated that the charge nurse would give the resident an OOP slip, which should be handed to the receptionist on the way out the door. REC stated that there was no OOP slip with Resident 199's name among the slips from 7/23/25. REC added that she would not know if Resident 199 had gone out the door, as she did not know who Resident 199 was and was not familiar with all the residents' faces.During a concurrent interview and review of the OOP binder at the nurse station on 7/24/25 at 5:17 p.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated, first, there should be an order written for OOP before a charge nurse issued the OOP slip to a resident. RNS 2 stated if there was no OOP order in the clinical record, there would be no OOP slip given to the resident.During a telephone interview on 7/24/25 at 5:55 p. m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated she did not see Resident 199 at the start of the afternoon shift on 7/23/25. LVN 8 stated that around dinner time at 5:40 p.m., Resident 199 was missing and both DON and Administrator (ADM) were informed. LVN 8 stated she found an OOP order in the clinical record around 7-8 p.m.During an interview on 7/25/25 at 11:07 a.m. with LVN 5, who worked the morning shift on 7/23/25, LVN 5 stated she did not know Resident 199 had left the building. LVN 5 also stated if she had known, she would have stopped Resident 199, or checked if there was OOP order, and documented it in the clinical record.During a review of Resident 199's clinical record, the Progress Notes indicated the following:-7/16/25, Resident 199 attempted to elope from the facility, triggering the wander guard alarm. This licensed nurse, along with another nurse, promptly responded and safely redirected the resident back into the facility. The progress notes did not indicate Attending Physician (AP) 1 was notified of Resident 199's elopement attempt.-7/16/25, Resident 199 exhibited behavior posing danger to self and others. Statements made and behaviors raised significant concern for the resident's safety and mental stability. Resident 199 was aggressive, agitated and expressed paranoid delusions. Resident 199 refused redirection and appeared disoriented to time and place. Resident 199 was transferred to acute hospital -7/17/25, Resident 199 returned to facility, 5150 hold was dropped, resistive to the wander guard, but was re-assured it was okay to have it. [Resident 199] up running through facility. Redirection attempts [were] unsuccessful to stop running. [Resident 199] will be evaluated by facility psychiatrist in house. The clinical record did not indicate an evaluation was done by in house psychiatrist.-7/23/25 at 5:45 p.m., progress note marked invalid by LVN 8 on 7/23/25 at 11:51 p.m., indicated, Resident 199 was Unable to be found during rounds, this writer spoke with previous nurse and [Resident 199] was last seen at 2 p.m. at nursing station 1. Resident known to wander around building. Wander guard bracelet was noted on resident per report. At dinner, resident was still not seen and staff immediately started searching for resident in building around 5:42 p.m. Searched the whole building and unable to find resident. Informed MD, DON, and the administrator. SPPD (police department) called after searching inside and outside of facility and reported about missing resident.-7/23/25 at 5:45 p.m., written by LVN 8, After four hours of this writer shift resident has not returned to facility. DON and ADM informed. SPPD notified -7/23/25 at 8:36 p.m., recorded as late entry on 7/23/25 at 7:49 p.m. by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, for one of three (Resident 112) sampled residents reviewed for behavioral health services, the facility failed to follow the psychiatrist's recommendation when Complete Blood Count (CBC, a common blood test that measures various components of your blood that included red blood cells, white blood cells, hemoglobin, etc.), Basic Metabolic Panel (BMP, blood test that measures glucose, calcium, electrolytes, etc. to detect conditions such as liver and kidney disease and diabetes) and Urinalysis (UA, used to detect and manage disorders such as urinary tract infection, kidney disease and diabetes) and Culture and Sensitivity (C&S, used to diagnose urinary tract infection and guide antibiotic therapy) were not conducted.This failure had the potential to result in undetected abnormal blood levels due to current treatment. During a review of Resident 112's Resident Face Sheet (RFS), the RFS indicated Resident 112 was admitted to the facility in July 2024 with diagnoses that included cellulitis of the left lower limb, acute kidney failure, sepsis (life-threatening condition in response to an infection) and essential hypertension (high blood pressure), prediabetes (blood sugar levels are higher than normal but not high enough to be diagnosed as type 2 diabetes), and asthma.During an interview on 7/22/25 at 3:30 p.m. with Administrator (ADM), ADM stated Resident 112 allegedly attempted to touch Resident 19's arm. Resident 19 did not like the gesture and said, Don't touch me. ADM stated the incident ended with no further issues between the two residents.During a review of Resident 112's Progress Notes dated 3/21/25, the Progress Notes indicated Resident 112 cried and was emotionally distressed after the incident.During a review of Resident 112's Physician Order Report, dated 7/24/25, the Physician Order Report indicated an order dated 3/24/25 for psychiatric evaluation related to the physical altercation. The Physician Order Report also indicated an order dated 12/5/24 for Resident 112 to receive Seroquel (treats psychosis) 50 milligrams (mg) by mouth in the morning at 9 a.m. and 100 mg. tablet in the evening at 9 p.m. for agitation.During a concurrent interview and record review on 7/24/25 at 9:14 a.m. with Minimum Data Set Coordinator (MDSC), MDSC stated that there was no documentation in the clinical record indicating Resident 112 had been seen by a psychiatrist. MDSC stated they would check with Medical Records to see if there was anything that had not been uploaded to the electronic chart.During a concurrent interview and record review on 7/24/25 at 10:52 a.m. with MDSC, MDSC provided a copy of the psychiatrist recommendation, which she said was with the Social Services Department. A review of the Psychiatrist Visit Progress Report (PVPR) indicated, There are no immediate psychiatric or behavioral concerns per staff, therefore will recommend GDR (Gradual Dose Reduction, process to slowly decrease the dosage of a medication, particularly psychotropic drugs, to determine if patient can maintain stability on a lower dose or if the drug can be discontinued altogether) trial of quetiapine [Seroquel]. Under Medication Order, the PVPR also indicated to consider obtaining blood work (CBC, BMP/UACS) to rule out underlying medical issues with behavior changes. The evaluation also included a Physician's Telephone Orders dated 6/10/25 to decrease the 50 mg. dose to 25 mg. once daily. During a review of Consultant Pharmacist's Medication Regimen Review (CPMRR) dated 6/16/25, the CPMRR indicated, I do not see any notation/document that the resident was seen by the psychiatrist. Resident [112] is on Seroquel for agitation which is not an acceptable diagnosis for the use of an antipsychotic agent. In addition, he had a recent unwitnessed fall- Seroquel may be a contributing factor. Please follow-up psych[iatric] consult to assess Seroquel order.During an interview on 7/24/25 at 11:10 a.m. with Director of Nursing (DON), DON stated she was just now looking at the psychiatrist's recommendation for the first time and would get back to this writer as soon as she found out what happened. MDSC was with DON, and both were looking into Resident 112's chart.During a concurrent interview and review of Resident 112's PVPR on 7/24/25 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated the PVPR dated 6/9/25 indicated GDR and laboratory tests, but the clinical record did not indicate any of the recommendations were done. LVN 4 stated the clinical record did not indicate that a GDR had been performed since Resident 112's admission to the facility in July 2024. LVN 4 stated the last laboratory test was dated 8/22/24.During a review of Resident 112's Progress Notes written by DON, with a run date of 7/24/25 at 12:17 p.m., the Progress Notes indicated an entry dated 6/12/25 at 11:46 a.m., recorded as late entry on 7/24/25 at 11:49 a.m. The Progress Notes indicated AP did not agree with the recommendation at the time due to Resident 112's behavior. Another Progress Notes written by DON indicated, Resident had been experiencing some tearfulness, and we went over the recommendations from the Psych evaluation and [AP] agreed to the GDR which I have changed as of today.During a review of Resident 112's Behavioral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews and record reviews the facility failed to ensure Resident 91 was updated regarding the status of her power wheelchairThis deficient practice had the potential to result in a significant impact on the resident's independence, quality of life, physical and mental health. During a review of Resident 91's Face sheet, dated 7/24/25, the Face sheet indicated, an initial admission date of 11/3/2018 and latest return date of 7/20/25. During a review of Resident 91's Face sheet, dated 7/24/25, the Face sheet indicated, Resident 91 had diagnoses to include: chronic obstructive pulmonary disease (COPD-chronic lung disease that makes it hard to breathe), diabetes mellitus type 2 (body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), chronic pain, anxiety disorder (excessive, persistent, and unreasonable fear and worry, often interfering with daily life), Major Depressive Disorder (MDD,persistent sadness, loss of interest, and other symptoms that significantly impair daily life), hypertension (high blood pressure), osteoarthritis (condition that causes joints to become painful and stiff), generalized muscle weakness and severe morbid obesity (a severe form of obesity characterized by a Body Mass Index (BMI) of 40 or higher, or a BMI of 35 or higher with obesity-related health complications. This condition significantly increases the risk of various health problems and can reduce life expectancy) During a review of Resident 91's Minimum Data Set (MDS-standardized assessment tool used to evaluate the health and functional status of residents), dated 4/22/25, the MDS indicated, the following: Section C (Cognitive Patterns-way of thinking) show a Brief Interview for Mental Status (BIMS-cognitive screening measure that focuses on orientation and short-term word recall) score was 15 (cognitively intact per BIMS score scale). The MDS Section GG (Functional Abilities) noted Dependent to moderate assist. During an interview on 7/21/25 at 3:56 p.m. with Resident 91, Resident 91 stated that she recently came back from the hospital. Resident 91 also stated that her electric wheelchair has been broken for about a year and that she has not been able to go out and do the things she like to do, like go to Dollar Tree or Ross right down the street. Resident 91 stated that she has not heard anything back regarding the power wheelchair and is using the manual wheelchair she is currently in but it is difficult to be as mobile as was when she had her power wheelchair. During a concurrent interview and record review on 7/23/25 at 12:36 p.m. with Social Worker (SW), Resident 91's Progress Notes dated 8/30/24, 12/10/24, 2/7/25 and 2/28/25 were reviewed. The Progress Notes for each date indicated: 8/30/24: Restorative Nursing Assistant (RNA) to weigh resident 91 in order to move forward with power wheelchair, 12/10/24: Facility received call from Durable Medical Equipment (DME) facility requesting resident 91 power wheelchair paperwork to be faxed on 11/25/24 that was refaxed 12/10/24, 2/7/25: A written order from provider was faxed to DME facility, 2/2/28/25: Facility received call from DME facility that resident 91 has an appointment in the facility 3/13/25 at 12:00 p.m. to assess her power wheelchair and resident 91 was made aware. SW stated the dates 8/30/24, 12/10/24, 2/7/24 and 2/28/25 were the only dates that could be found regarding the power wheelchair. SW stated that could not find documentation regarding 3/13/25 DME visit to the facility. The SW also stated that there should be document in the chart for this visit but I don't see it. During a concurrent interview and record review on 7/23/25 at 3:24 p.m. with SW, Resident 91's Insurance Letter, dated 4/30/25, was reviewed. The Insurance Letter indicated, that resident 91 was denied authorization for a power chair and that there was no follow up that can be found after that. SW also stated that resident 91 was informed at that time that authorization for the power wheelchair. During an interview on 7/23/25 at 3:49 p.m. with resident 91, resident 91 stated that it was as I told you before, I was not aware of any denial letter and nobody told me anything. Resident 91 also stated that I thought that they was still working on getting my power chair. During a review of the facility's policy and procedures (P&P) titled, Social Services, [undated], the P&P indicated, .2. The director of social services is responsible for.maintaining records related to social services.meeting or assisting with the medically-related social service needs of residents.3.Medically-related social services are provided to maintain or improve each resident's ability to control everyday physical needs (e.g. appropriate adaptive equipment for eating, ambulation, etc); and mental and psychosocial needs (e.g. sense of identity, coping abilities, and sense of meaningfulness or purpose.5. The social worker/social services staff are responsible for.making referrals and obtaining needed services from outside entities. During a review of the facility's policy and procedures (P&P) titled, Resident Rights, [undated], the P&P indicated, .Residents have freedom of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling when: 1.One Breyna or Budesonide-Formoterol-Fumarate inhaler labeled only with a room number was found in medication cart 2 (an inhaler is a device used for delivering medicines into the lungs through breathing; Breyna is the brand name of Budesonide-Formoterol-Fumarate inhaler, and is a medication indicated for the treatment of breathing difficulties). 2. Two opened bottles of Refresh eyedrops (lubricating eye drops designed to soothe and relieve dry, irritated eyes) were found in medication cart 4. 3. Resident 11's one opened Incruse Ellipta inhaler was found with no open date label in medication cart 1 (Incruse Ellipta is an inhaler used to prevent and control symptoms associated chronic obstructive pulmonary disease or COPD, a long-term lung disease that makes it hard to breathe). 4. One opened unlabeled Nystatin powder and one unlabeled open tube of TheraHoney gel were found at Resident 121's bedside table (Nystatin is a skin medication used to treat skin infections, TheraHoney is a skin medication used to heal wounds). 5. One used Purified Protein Derivative (PPD) vial was found with no open date label in Station 2's medication refrigerator (PPD is a substance used in skin tests to help detect tuberculosis infection - a contagious infection caused by bacteria that usually attack the lungs but can also affect other parts of the body). 6. One box of expired insulin syringes was stored in Station 2's medication room (insulin syringes are disposable tools designed to help people with diabetes inject insulin into their bodies; insulin is a medication that lowers blood sugar). 7. 12 loose pills were found in medication cart 3. Findings:1.During a concurrent observation and interview on [DATE], at 1149 a.m., with the Registered Nurse (RN) 1, while inspecting medication cart 1, observed an opened Breyna box with inhaler with no label except for the room number. The box of the inhaler had a handwritten note which read, 28 C. RN 1 stated that the inhaler belonged to Resident 121. Also stated Resident 121's inhaler should have been labeled with the resident's name and dosage, to prevent medication error. During a review of Resident 121's Facesheet (information containing contact details, brief medical history at-a-glance) indicated Resident 121 was readmitted to the facility on [DATE]. During a review of Resident 121's Physician Order (PO), dated [DATE], the PO indicated an order of Budesonide-Formoterol inhaler 2 puffs twice a day for COPD. During an interview on [DATE] at 3:25 p.m., the Director of Nursing (DON) stated all the residents' medications should have been labeled with the resident's name, dosage, open date and the initial of nurse who opened the medication and not just room number to prevent medication error. 2. During a concurrent observation and interview on [DATE], at 10:50 a.m., with the Licensed Vocational Nurse (LVN) 7, while inspecting medication cart 4, observed 2 opened boxes of Refresh eyedrops with just room [ROOM NUMBER] A written in both boxes. LVN 7 stated the eyedrops belonged to Resident 146. Stated the eyedrops should have been labeled with the resident's name and dosage to prevent medication error. Review of Resident 146's facesheet indicated the resident was admitted to the facility on [DATE]. A review of Resident 146's PO, dated [DATE] indicated an order of artificial tears OTC 1%, 1 drop in both eyes for dry eyes 3x a day (OTC means over the counter, Refresh Tears are a brand of artificial tears). During an interview on [DATE] at 3:25 p.m., the DON stated all the residents' medications should have been labeled with the resident's name, dosage, open date and the initial of nurse who opened the medication and not just room number to prevent medication error. During a review of the facility's policy and procedure titled, Medication and Medication Labels, dated 2007, indicated, . Medications are labeled in accordance with currently accepted professional principles including appropriate auxiliary and cautionary instructions to promote safe medication use following state and federal laws.1. Each prescription medication will be labeled to include a. Resident's name b. specific directions for use including route of administration. 3. During a concurrent observation and interview on [DATE], at 1149 a.m., with RN 1, while inspecting the medication cart 1, Resident 11's Incruse Ellipta inhaler was found with no open date label. RN 1 stated the inhaler should have had an open date label, because of the risk for Resident 11 to receive medication with less potency. During a review of box of Incruse Ellipta inhaler indicated, Discard the inhaler 6 weeks after opening the moisture protected foil tray . (The moisture protected foil tray is designed to safeguard the medication from moisture, which can decrease the inhaler's effectiveness).During a review Resident 11's Facesheet indicated the resident was admitted on [DATE]. During a review of Resident 11's Physician Order, dated [DATE], indicated an order for Incruse Ellipta inhaler 1 puff daily for COPD.During a review of Resident 11's Medication Administration Record (MAR) indicated Incruse Ellipta inhaler was last given on [DATE] at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. Based on observation, record reviews and interviews, the facility failed to ensure that Resident 53 was provided with up-to-date annual dental services.This deficient practice had the potential to result in the resident experiencing pain, infection or difficulty eating which could lead to potentially decreased nutritional intake and weight loss.Findings:During a review of Resident 53's Face sheet, dated 7/24/25, the Face sheet indicated, resident 53 was admitted to the facility 1/11/18. During a review of Resident 53's Face sheet, dated 7/24/25, the Face sheet indicated, Resident 53 had medical diagnoses to include altered mental status (change in a person's level of consciousness, alertness, and cognitive function), dementia (loss of memory, language, problem-solving and other thinking abilities), muscle weakness, dysphagia (difficulty swallowing) and visual impairment.During a review of Resident 53's Minimum Data Set (MDS-standardized assessment tool used to evaluate the health and functional status of residents), dated 7/16/25, The MDS indicated, the following: Section C (Cognitive Patterns-way of thinking) show a Brief Interview for Mental Status (BIMS-cognitive screening measure that focuses on orientation and short-term word recall) score was 3 (severe cognitive impairment per BIMS score scale), Section GG (Functional Abilities) noted Dependent assist (helper does all of the effort), Section K (Swallowing/Nutritional Status) noted with no check marks/documentation in this section at time of this survey and Section L (Oral/Dental Status) noted with no check marks/documentation in this section at the time of this survey.During a concurrent observation and interview on 7/21/25 at 12:11 p.m. with Resident 53 in their room, Resident 53's mouth was observed swollen gums with no teeth on the bottom row. Resident 53 stated, that at times it hurts to eat.During a review of the electronic health record (EHR) Provider Orders for Resident 53, dated 8/27/23, the Provider Orders indicated, Diet Order to be as follows: Regular: Pureed (all foods are blended or pureed to a smooth, pudding-like consistency); 1:1 Assist with feeds; Aspiration Precautions ; May have soft snacks such as bananas and soft sandwiches. and Refer for Dental Consult annually and as needed (if stay is long term). During a concurrent interview and record review on 7/22/25 at 1:04 p.m. with Social Worker (SW) in their office, EHR or hardcopy of dental records could not be found. SW stated that they always have a copy of gets dental done and we have a binder. SW stated that resident 53 has no teeth, so did not think needed an exam. SW stated that was unsure as to when resident 53 got their last annual dental exam. SW stated that Dental come often for the annual exams of the residents and they do it it in batches but could not find any recent record for resident 53.During a concurrent interview and record review on 7/22/25 at 1:04 p.m. SW in Facility Conference room, last documented record of an annual dental exam in the EHR or hardcopy was 11/2/22 with recommendation for annual exam.During a review of the facility's policy and procedures (P&P) titled, Dental Services, [undated], the P&P indicated, Routine and emergency dental services are available to meet the resident's assessment and plan of care.5. Social Services representatives will assist residents with appointments.6. Direct care staff will assist residents with denture care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe, sanitary storage of food when:Multiple opened food items stored in the dry storage and refrigerators did not have open dates and use-by dates.Paper bag with food labeled 7/14 stored in the refrigerator had directions give to resident next day This failure had the potential to place all residents getting meals from the kitchen to be at risk for foodborne illness potentially leading to hospitalization or death. 1. During an observation and concurrent interview on 7/21/25 at 8:50 a.m., in the kitchen, refrigerator #2 had an opened box of cheesecake, with no open date and no used-by-date. The Registered Dietician (RD)stated he does not know when it was opened. RD stated opened refrigerated cheesecake was good for five days. In the dry storage room, five prepared bowls of dry cereal did not have open date and no use-by-date. RD stated the bowls of cereal should indicate when it was prepared and have a use-by-date. In a storage container of aluminum sealed items, were two eaten banana peels and a soiled paper cup. In the unnumbered nourishment refrigerator, an opened gallon of milk and orange juice pitcher did not have an open dates and no use-by-dates. During a record review of the facility P&P titled, Sanitation and Infection Control Subject Food Receiving and Storage of Cold Foods, dated 2023, the P&P indicated all open food items will have an open date and use-by-date per manufacturer's guidelines .cold food storage areas will be clean, dry, and free of contamination. During a review of the facility P&P, titled Sanitation and Infection Control Subject Canned and Dry Good Storage, dated 2023, the P&P indicated all food items will have an open date and use-by-date per manufacturer's guidelines .the storage area will be cleaned and maintained. 2. During an observation and concurrent interview on 7/21/25 at 8:53 a.m., a paper bag labeled for a resident dated 7/14/25, had instructions Dialysis bag for next day at 9AM. The RD identified the items in the bag to have a ham sandwich and two fruit cups. The RD stated the ham sandwich was good for 7 days so it was good until tonight. During a record review of the facility P&P titled, Sanitation and Infection Control Subject Refrigerated Storage, dated 2023, the suggested refrigerated storage guidelines indicated luncheon meats to be stored until their expiration date or less than or equal to 7 days of opening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an effective infection control program when:1.The specimen refrigerator (a specimen refrigerator is a specialized cooling unit used to store various biological samples collected from patients, such as urine, stool, blood, or tissue) was observed to be stored in the same room with the ice container for residents' consumption. 2. Station 2 medication storage room drawer was found to be disorganized and contained medications mixed with specimen sample containers, central line dressing kit, needles and socks stored together. (a specimen container is used to store various biological samples collected from patients, such as urine, stool, blood, or tissue; Central Line Dressing kits are used for very clean resident dressing changes). These failures placed the facility residents at increased risk of healthcare associated infections. Findings:1.During a concurrent observation and interview on 7/22/25, at 4:19 p.m., with Registered Nurse Supervisor (RNS) 3, in the Station 1 utility room, the specimen refrigerator was observed to be stored in the same room with the ice container that held ice cubes used for consumption by the facility residents. The scooper used to get ice from the ice container was observed to be hanging in the wall exposed to air beside the ice container. Also, observed inside the specimen refrigerator were stool specimens, urine specimen samples and blood samples. RNS 3 acknowledged that the risk of having the specimen refrigerator and the ice container in the same room was spread of infection. During an interview on 7/23/25 at 12:16 p.m., with the Infection Preventionist (IP), IP stated, the risk of having the ice container and the specimen refrigerator in the same utility room was the risk of the spread of infection to the residents who were using the ice for oral consumption. Also stated the risk of having the ice scooper hanging in the wall exposed to air in the utility room was cross contamination. 2. During a concurrent observation and interview on 7/21/25, at 8:58 a.m., with RN 1, in Station 2 medication storage room, the drawer was found to contain two boxes of Lidocaine patch medications, specimen sample containers, unused needles, test tubes, a pair of unused socks and a central line dressing kit mixed untidily together. RN1 acknowledged that the medication room drawer should be clean and orderly and should not store medications, needles and central line dressing kit due to the risk of spread of infection to the residents if these supplies were used. During an interview on 7/23/25 at 12:16 p.m., with the IP, IP stated, the medication storage drawers should be tidy and clean. Further stated that the lidocaine patches, needles and central dressing kit should not be mixed with the specimen containers and socks due to the risk of cross contamination and spread of infection. During an interview on 7/23/25 at 3:25 p.m., with the DON, stated, the risk of having the medication storage drawer storing medications, needles and central sterile dressing mixed with specimen containers was infection control. During a review of the facility's policy and procedure (P&P) titled, Infection Control Program, updated 11/22/21, the P&P indicated, . The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance . prevention of infection .and safety . Prevention of Infection a. Important facets of infection prevention include . 2) instituting measures to avoid complications or dissemination; (3) educating staff and ensuring that they adhere to proper techniques and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility had three Resident rooms (Rooms 35, 41 and 43) with multiple beds that provided less that 80 square feet (sq. ft) per Resident who occupied these roomsThis deficient practice had the potential to result in inadequate space for the delivery of care to each Resident in each of these rooms and/or for storage of the Resident's belongings.Findings: During an observation 7/24/25 at 3:15 p.m., following rooms and corresponding sq. ft per bed were identified: room [ROOM NUMBER] had three beds, total sq. ft. is 231.6 and 77.2 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 231.6 and 77.2 sq. ft. per bed. room [ROOM NUMBER] had three beds, total sq. ft. is 231.6 and 77.2 sq. ft. per bed. During an interview on 7/24/25 at 12:32 p.m. with Resident 107, Resident 107 stated regarding the room size that it feels at little like a cubicle but making do and not to bothersome.During an interview on 7/24/25 at 12:43 p.m. with Resident 44, Resident 44 stated regarding the room size that it was ok, was not to bothersome and that she felt she had enough room to place her personal belongings.During an interview on 7/24/25 at 12:49p.m. with Resident 99, Resident 99 stated regarding the room size that it was fine and had no issues with space for her belongings.During an interview on 7/24/25 at 12:46 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated that they are staff personnel for the facility and has worked here for a while. CNA 4 stated that has worked and is currently working with the Residents in room [ROOM NUMBER]. CNA 4 stated the room size is adequate to provide care and for the Resident's belongings. CNA 4 stated that has not had issues with Resident transfers (moving a Resident from one place to another) or using wheelchairs in the room. During an observation on 7/24/25 at 12:32 p.m. of Resident room [ROOM NUMBER], no heavy medical equipment was observed that might interfere with each Resident's care. During an observation on 7/24/25 at 12:43 p.m. of Resident room [ROOM NUMBER], no heavy medical equipment was observed that might interfere with each Resident's care.During an observation on 7/24/25 at 12:49 p.m. of Resident room [ROOM NUMBER], no heavy medical equipment was observed that might interfere with each Resident's care.There were no complaints from any Residents in rooms 35, 41 and 43 regarding insufficient space for their belongings. There are no negative consequences that can be attributed to the decreased space and/or safety concerns in these rooms. Granting the room size waiver is recommended.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vale Healthcare Center	13484 San Pablo Avenue San Pablo, CA 94806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record review and interviews, the facility failed to provide call system (allows patients to request assistance from healthcare staff, typically nurses, by activating a call button or other alerting device. These systems are crucial for patient safety and efficient care delivery, enabling patients to quickly summon help when needed) to Resident 107.This deficient practice had the potential to result in resident having trouble accessing help for medication needs basic comfort or hygiene needs to prevent falls. Findings:During a review of Resident 107's Face sheet, [undated], the Face sheet indicated, Resident 107 was admitted to the facility 4/9/24 and has diagnoses to include Chronic Obstructive Pulmonary Disease (COPD- condition caused by damage to the airways or other parts of the lung), Fracture of Left and Right Humerus (break in the upper arm bones), Vertigo (sensation that you or your surroundings are spinning or moving) Anxiety (feelings of worry, nervousness, or unease) and Depression (mood disorder that can affect how you think, feel, and handle daily activities). During an observation on 7/24/25 at 12:32 p.m. in Resident 107's room, above Resident 107's bed, there was no call light observed attached to the wall or at the bedside. There was also no call bell observed on the bedside table. During an interview on 7/24/25 at 12:32 p.m. with Resident 107, Resident 107 stated that he had not had a call bell for a long time. Resident 107 also stated that if he needed medications such as his pain or sleep medication, he would have to use his wheelchair to wheel himself to the nurses station to request them.During an interview on 7/24/25 at 12:34 p. m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that it is important for the resident to have a call light because what if he can't get up. LVN 4 stated that will contact Maintenance to have a call light installed into the wall but will get bedside table call bell in the meantime.During a review of the facility's policy and procedure (P&P) titled, Resident Call System, [undated], the P&P indicated, Residents are equipped with a communication system allowing them to request assistance by contacting either a staff member directly or a centralized work station.3. The resident call system remains functional at all times.5. The resident call system is routinely maintained and tested by the maintenance department.